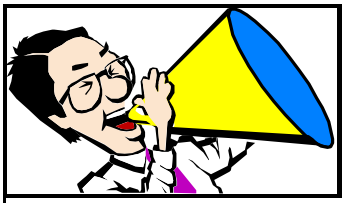

WILLIE M. EVALUATION NEWS

VOLUME I, ISSUE 1 FALL 1997

FROM THE EDITOR

The time has finally come for all of us who work with **Willie M**. youth to reap the benefits available from the information being gathered in our various service outcomes research.

Hard work has been ongoing, by case managers, service managers, clinicians, educators, paraprofessionals, and others all over the state, administering Assessment and Outcome Instruments (AOIs), Appropriateness Reviews (ARs), Simple Checklists, and various other surveys. We are to the point, at last, that we can relay findings to those working "in the field" with **Willie M**. youth, to enhance our understanding, improve our interventions, and generate questions to be asked in the future.

We hope that you will read this newsletter as a way of benefiting from your own work in gathering important information. We also hope you will give us ideas for new questions to ask, or interpretations from your own experiences. As we begin to gather three or four years of consecutive data on a child's progress, we may truly come to understand how **Willie M**. services are working, or when they are not. We hope that this newsletter will provide you with useful information that helps you. Our primary aim is to disseminate information that aids your practive in serving clients.

Most importantly, we rely on the careful and conscientious dedication of case managers and others to continue to provide us with this valuable information, in an ongoing way, so we can continue to be on the "cutting edge" of outcomes evaluation, and "state of the art" in our services to this most challenging population of high-risk youth!

We welcome any feedback or questions about the outcomes research or its implications for clinical practice with **Willie M**. children. You can address comments or questions to: Eric Vance, MD., Chief Clinical Consultant, **Willie M**. Section, 3509 Haworth Drive, #302, Raleigh, NC., 27609, E-mail: evance@haworth.dhr.state.nc.us

NOW, SOME OF THE FIND-

EDUCATIONAL PROGRESS & PROTECTIVE FACTORS

We recently completed a detailed look at the relationship between the educational progress of a **Willie M**. child and the child's possession of risk and protective factors.

In looking at this data, we find a very strong relationship between the total number of protective factors and positive school progress. We also find some specific, individual factors which seem to predict positive educational progress among class members. Not surprisingly, problem-solving and reading abilities predict good school function.

More interestingly, and *just as important*, is the finding that the ability to get along with other children and adults, and general "likeability" are strongly associated with educational progress.

Having an adult at school, who makes an extra effort to reach out (a school-based mentor) also has a powerful positive effect.

Finally, several individual risk factors, including substance use and family stress factors, predict poor performance. These findings have important implications for designing individualized interventions for class members who are having difficulty with educational progress, such as recruiting adults from school to reach out to the child, or training the child in problem-solving skills.

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POSITIVE CHANGES OVER TIME

One of the benefits of looking at the AOI each year, for each child, is to monitor the progress each is making in various areas of life function.

We recently looked at the AOI data for 395 class members statewide with at least two successive AOIs.

In looking at the changes in key indicators of desired outcome over a year, we see there is a general trend towards positive movement in every key indicator of functioning!

There are large positive changes towards living in less restrictive settings over time, and also an increase in the prevalence of emotional support from mentors statewide. The average child acquired over four new protective factors, while adding less than two new risks. ***This adds up to the conclusion that overall we are making a positive difference.***

When we look at the effect of residence, we find some important trends. First, we find positive trends in educational progress for children in group homes, and negative trends for those in institutions or living in their natural home. Perhaps the structure of a group home ensures that a child makes it to school. We know that predictable behavioral consequences usually arise for a bad day in school.

On the other hand, mentor support tends to grow in all settings except in group homes, where it tends to diminish. Does this result mean that group home staff are less likely to act as mentors to the children they serve? Or does it mean that these children are simply harder to bond with?

Emotional support from the child's family appears to grow if they are in therapeutic homes or living at home, while family support diminishes if a child lives in an institution or group home for the year. Finally, protective factors seem to accumulate fastest if a child lives in therapeutic foster care, but grow in all other settings as well, though slowest in an institutional setting.

Not surprisingly, we find that **Willie M.** children continue to accumulate risk factors as they get older, regardless of the setting. This accumulation was slowest in group homes and fastest in therapeutic homes.

The good news is that Willie M. children are acquiring protective factors faster than risks.

NEWLY-CERTIFIED CHILDREN

We compared the AOI information from newly-certified children (certified less than three months) to the AOI data from children who have been class members for a longer time.

We looked at the prevalence of frequent, severe behaviors such as assaults, serious threats, and self-injury, and found that between two and three times as many newly certified children displayed these behaviors daily or several times a week. This suggests that time receiving **Willie M.** services probably serves to fairly quickly decrease the frequency of severe behaviors.

This echoes the finding of a recent study on service use and outcomes, which found that length of time in the **Willie M.** class resulted in less incidents of violence and progressive movement towards less restrictive environments (Farmer, 1996). The lowest level of violence was exhibited by those children living in therapeutic homes. She also found that those children living in their natural home received the least services, while those living in group homes or other staffed residences received the most.

Without more study, we cannot tell whether children who receive more services truly need more, or are simply easier to provide for than those living at home.

As we begin to look more closely at the AOI outcomes of children as they receive certain types of services, we should begin to understand which services work best for which children.

WHAT IS THE AOI?

Outcomes Evaluation is the process of examining programs for their results in terms of *client progress* rather than in terms of how many clients they serve or how much they cost. The trend of evaluating the value of programs in this way has recently become important in governmental programs interested in being seen as "results-oriented." The process consists of collecting information, analyzing data, and modifying the approach based on what is learned

RESILIENCY THEORY AT WORK!

As we are all aware, Resiliency theory has been embraced by a wide array of workers and planners for high-risk youth.

It is increasingly clear that only those children who possess a great number of psycho-social protective factors have a good chance of rising above the enormous burden of the risk factors found in the **Willie M.** population.

The Assessment and Outcomes Instrument (AOI) contains a comprehensive inventory of each child's risk and protective factors, which not only allows us to determine the level of risk factors we are up against, but also calculates the number of protective factors present for the child.

Compared to the usual cut-off of 4-5 risk factors for a "high-risk" child, 15 is the average for a **Willie M.** child! The number is slightly higher for our girls.

Surprisingly, there is an average of 12 protective factors per **Willie M.** child, which sounds like a lot; but it is far from the possible 30 protective factors found in healthy or resilient children. This leaves plenty of room for interventions aimed at building protective factors into the lives of **Willie M.** youth to increase their odds of positive life outcomes.

How well do risk and protective factors predict positive life outcomes? In looking at desirable outcomes for **Willie M.** children in the realms of educational progress, decreasing severe behaviors, increasing social support networks, maintaining good health, and decreasing the need for residential restrictiveness, we find some confirmation that degree of resiliency, as measured by AOI risk and protective factors, is a strong predictor of good outcome.

The total number of *protective factors* predict positive status, or progress in education, family support, mentor support, residential status, and dereasing frequency of *aggressive* behaviors. Total number of *risk factors* predict poor outcome in areas of family support, risk-taking, and threatening behaviors.

In general, the outcomes of **Willie M.** girls are harder to predict. This echoes other findings from the AOI that show our females have higher psychiatric symptom severity, more severe behaviors, and higher risk factors.

All in all, the information from the AOI suggests that as we build protective factors, we build positive life outcomes. To apply this knowledge is to focus interventions on identifying areas where protective factors can be fostered, and making this resiliency-building process a priority in T/HP planning.

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CLINICAL SYMPTOMS OF WILLIE M. CHILDREN

The Brief Psychiatric Rating Scale for Children (BPRS-C) is a symptom rating filled out by a clinician as part of the AOI.

The BPRS-C includes symptoms of behavior problems, depression, thought disturbance, motor agitation, withdrawal, anxiety, organic disturbance, and socialiation problems. When we use the information from the BPRS-C to look at large numbers of children, the most severe ratings are in uncooperativeness, manipulativeness, mistrust, peer relationships, distractibility, hostility, adult relationships, and feelings of inferiority.

These severe symptoms are familiar to those who have worked with this population. Not only are the symptoms indicative of oppositional and conduct disorder (being uncooperative, manipulative), but also point to the frequency of abuse effects (mistrust, relationship difficulties), and depression (hostility, inferiority).

Understanding the origins of these symptoms can help practitioners focus on building a trusting relationship with the child as attempts are made to treat underlying behavioral problems, depression, or abuse effects.

Mistrust of people trying to help may be the single biggest, undiagnosed obstacle to effective habilitation.

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